Issue Date: 21 March 2007 **Department of Labor**
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Office of Administrative Law Judges

In the Matter of:

C.C.,
Claimant,

CASE NO: 2006-BLA-5706

v.

CLINCHFIELD COAL COMPANY,
Employer,

and

PITTSTON COMPANY,
c/o ACORDIA EMPLOYERS SERVICE,
Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

Appearances:

Andrew Delph, Esq.
For the Clamant

Timothy W. Gresham, Esq.
For the Employer

Before: Larry W. Price
Administrative Law Judge

DECISION AND ORDER – DENYING BENEFITS

This a subsequent claim for benefits under the Black Lung Benefits Act, Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. 901 *et*

seq. (Act), and applicable Federal Regulation, mainly 20 C.F.R. Parts 412, 718, and 725 (Regulations).

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to coal workers' pneumoconiosis or to the survivors of persons whose death was caused by coal workers' pneumoconiosis. Coal worker's pneumoconiosis, commonly known as black lung, is defined in the Act as "a chronic dust disease of the lung and its sequelae, including pulmonary and respiratory impairments, arising out of coal mine employment." 30 U.S.C. 902(b).

On May 10, 2006, this case was referred to the Office of Administrative Law Judges for a formal hearing. The hearing was held in Abingdon, Virginia on October 24, 2006. Both parties submitted a post-hearing brief.

At the hearing I admitted Director's exhibits 1 through 42, Claimant's exhibit 1 and Employer's exhibits 1 through 17.[1] Employer submitted the two x-ray interpretations found at EX 12 and 13 not as part of the new evidence associated with the instant subsequent claim, but rather as rebuttal to two x-rays obtained by the Department of Labor in a prior claim. The claim was denied before Employer could rebut the x-rays. Therefore I admitted Employer's exhibits 12 and 13 with the limited purpose of rebuttal evidence to be considered in conjunction with the record as a whole. These x-ray interpretations will only be relevant if Miner meets the threshold standard for this subsequent claim. I will only consider the record as a whole if the new evidence establishes the existence of an element previously adjudicated against Miner. 20 C.F.R. § 725.309(d)(3).

ISSUES

The following issues remain for resolution:

- Whether the new evidence establishes the existence of an element previously adjudicated against Miner.
- Existence of pneumoconiosis.
- Whether pneumoconiosis arose from coal mine employment.
- Total disability.
- Whether total disability was caused by the pneumoconiosis.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The parties have stipulated to the following and I therefore find the following facts:

- That Claimant, hereinafter referred to as Miner, is a miner as defined by the Act and was employed as a coal miner for 17 years.

[1] The following abbreviations have been used in this decision: DX – Director's Exhibit; EX – Employer's Exhibit; CX – Miner's Exhibit; TR – Transcript of the January 10, 2006 hearing; BCR – Board certified radiologist; and B – B-Reader.

- That Miner worked as a miner after 1969.
- That a written claim for benefits was timely filed on April 22, 2005.
- That Miner's wife is recognized as a dependant under the Act.

Procedural History

Miner initially filed for federal black lung benefits on April 2, 1992, which was denied by the district director on May 20, 1992. (DX 1).[2] Miner filed a second application on October 6, 1993, which was ultimately denied by the district director on July 30, 1994. (DX 1). Miner twice requested modification of this denial. The district director denied both modifications, first on November 7, 1995, then again on September 5, 1996. Miner then requested a hearing. Judge Mollie Neal found that Miner failed to establish the presence of pneumoconiosis or total disability and therefore denied benefits on November 10, 1997. (DX 1). The Benefits Review Board affirmed Judge Neal's decision on December 9, 1998.

Miner filed a third claim for benefits on January 3, 2000. (DX 2). The district director denied the claim on March 6, 2000. Miner did not challenge that denial, but rather filed a fourth claim for benefits on July 5, 2002. (DX 3). The district director denied benefits in a Proposed Decision and Order dated April 21, 2003. Miner once again did not challenge the denial and instead filed a fifth application for benefits on April 22, 2005. (DX 5). The district director initially concluded that Miner would receive benefits in the Schedule for the Submission of Additional Evidence. (DX28). However, following the submission of additional evidence the district director issued a Proposed Decision and Order denying benefits on January 12, 2006. (DX 35). The district director found that Miner did have a respiratory disability, but was unable to prove the existence of pneumoconiosis. Miner requested a hearing on January 31, 2006. (DX 37).

Background

Miner was born on December 26, 1935 and currently lives in Honaker, Virginia. (DX 5, DX 40). He married his wife on January 30, 1960. (DX 11). They are still married. (Tr. at 22). Miner does not have unmarried children under the age of 18, disabled or between 18 and 23 and attending school. (DX 5). Miner has a sixth grade education. (DX 5). Miner reports working numerous positions in the mines, including general laborer, track man, belt cleaner, and belt installer. (DX 6). His last job in the mines was a shuttle car operator. (DX 6).

The record contains varied statements regarding the Miner's smoking history. Dr. Castle noted a smoking history of a half pack per day for 42 years. (DX 17). Dr. McSharry reported that the Miner had smoked half a pack for 40 years and quit in 1991.

[2] Miner was granted social security benefits for his breathing problems on June 15, 1989. (DX 1).

(DX 11). Dr. Rasmussen reported a 22.5 pack year smoking history. (DX 2). Dr. Bailey said Miner had smoked a little bit, but not much. (DX 22). Dr. Kramer noted a smoking history of 55-60 years at half a pack per day, and reported that Miner had cut down to a few cigarettes per day. (DX 22). Dr. Rao reported that Miner was formerly a heavy smoker, but had quit in 2005. (EX 5). Dr. Cox also acknowledged that Miner had smoked, but reported that Miner had quit in 2005. (EX 8). In 2000, Dr. Forehand noted a 50 pack year smoking history; he reported that Miner quit in 1998. (DX 2). Two years later, Dr. Forehand recognized a smoking history of ½ to ¾ of a pack per day from 1975 to 2000. (DX 3). In 1996, Dr. Sargent noted a smoking history in excess of 15 pack years and reported that Miner had quit in 1993. (DX 1 former DX 36). In 1993, in the Holston Hospital discharge summary, Miner's smoking history was listed as in excess of 30 pack years. (DX 1 former DX 31). Miner reported smoking a pack per day from between 1953 through 1993 in the Department of Labor exam in 1993. (DX 1 former EX 4). I find that Miner had smoked approximately ½ to ¾ of a pack per day for forty years, which would yield a 25 pack year smoking history. I find that Miner had cut down significantly in 1993, but had continued to smoke a few cigarettes per day up until 2005.[3] I find this to yield an additional 1.8 pack years. I therefore find that Miner has a 26.8 pack year smoking history.

Subsequent Claim Threshold

Miner's previous claim for benefits was informally denied on April 21, 2003; Miner failed to prove any necessary element of entitlement. (DX 3). Miner did not appeal this denial, and so the Proposed Decision and Order became final thirty days following its issue date. Miner filed the current claim more than a year later, on April 22, 2005 (DX 4), and therefore this claim constitutes a "subsequent claim" under the regulations. The provisions of Section 725.309(d) apply to subsequent claims and are intended to provide relief from the traditional notions of res judicata. Under Section 725.309(d), subsequent claims must be denied unless the evidence demonstrates that one of the applicable conditions of entitlement has changed since the prior denial. 20 C.F.R. § 725.309(d). The rulings of the United States Court of Appeals for the Fourth Circuit control in the adjudication of this case. Since this claim was filed after January 19, 2001, the regulations contained in 20 C.F.R. Part 718[4] as amended in 2001 are applicable.

To establish entitlement to benefits under this part of the regulations, a miner must prove by a preponderance of the evidence that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, that he is totally disabled, and that his total disability is due to pneumoconiosis. 20 C.F.R. §725.202(d); Anderson v. Valley Camp of Utah, Inc., 12 BLR 1-111, 1-112 (1989). In Director, OWCP v. Greenwich Collieries, et al., the U.S. Supreme Court stated that where the evidence is equally probative, the Miner necessarily fails to satisfy his burden of proving the existence of pneumoconiosis by a preponderance of the evidence. 114 S. Ct. 2251 (1994).

[3] I based my calculations upon three cigarettes per day between the years of 1993 and 2005.
[4] All of the regulations cited in this decision are contained in Title 20 of the Code of Federal Regulations.

The initial analysis is limited to a review of the condition or conditions of entitlement upon which the prior denial was based. If a Miner establishes the existence of an element previously adjudicated against him, only then must the administrative law judge consider whether all the evidence of record, including evidence submitted with the prior claim, supports a finding of entitlement to benefits. 20 C.F.R. § 725.309(d)(3). In the denial of Miner's prior claim, the district director had determined that Miner was unable to prove any element of entitlement. Therefore, if the newly-submitted evidence establishes the presence of pneumoconiosis or total disability, then I must review the entire record to determine entitlement to benefits.

NEW MEDICAL EVIDENCE

X-ray Reports

Exhibit	Doctor	Qualifications	Date of X-ray	Date of Reading	Film Quality	Interpretation
EX 11	Scott	B/BCR	9/12/06	9/15/06	1	Negative; as, co, em. Cardiomegaly. Hyperinflation of lungs compatible with emphysema.
CX 1 (p. 8), EX 10	Coburn	B/ BCR ***	7/7/06	7/7/06		The lung fields are free of any active infiltrates. No acute infiltrates and no evidence of congestive heart failure or pulmonary edema.
EX 4	David L Wood		3/1/06	3/1/06		Improvement of left lower lobe consolidation with minimal residual. No mention of pneumoconiosis.
EX 3	Terry M. Fletcher	BCR **	2/28/06	2/28/06		There is pulmonary vascular cephalization and mild increased interstitial markings. The lungs show no definite confluent process. Findings suggest pulmonary venous hypertension and perhaps mild interstitial edema.
CX 1 (p. 8)	Coburn	B/BCR	11/9/05	11/9/05		Shortness of breath, and previous x-ray showed nodular densities in the lower lung zone. No acute abnormalities status post median sternotomy with a left ventricular configuration, heart. Nipple markers were indeed placed on the nipples but no mass lesions could be demonstrated and these studies could be forwarded to Dr. Castle for his review in view of his letter to Miner in regards to possible nipple shadows over the lower lung zone.
DX 17	Wheeler	B/BCR	10/19/05	10/27/05	2	Negative
CX 10 (p. 8)	Susan B. Humphreys	BCR **	8/11/05	8/11/05		Mild chronic interstitial disease and old granulomatous disease. No acute alveolar infiltrate and no pleural effusion. Cardiomegaly.
DX 21	Abramowitz	B/BCR	7/19/05	9/13/05	1	0/1 s/t
DX 13	Taylor	No	7/19/05	7/19/05	1	1/1, p, 2z
DX 22,	Coburn	B/BCR	12/17/03	12/18/03		The lungs are hyperexpanded. There is evidence of median sternotomy. The lung fields are free

EX 1						of any active disease. No active disease
EX 13	John C. Scatarige	B/BCR	3/6/00	8/21/06	2, light	Negative, aa, em, OD – hyperinflation c/w emphysema – suggest clinical correlation
EX 12	William W. Scott	B/BCR	3/6/00	8/21/06	2, light	Negative; aa, em. Hyperinflation lungs compatible with emphysema.

* I take judicial notice of B-reader certification. This physician was identified as a B-reader in the NIOSH Comprehensive Reader List found at: http://www.oalj.dol.gov/PUBLIC/BLACK_LUNG/REFERENCES/REFERENCE_WORKS/BREAD3EF_08_05.HTM.

** I take judicial notice of board certification in radiology. The American Board of Medical Specialties provides this information at http://www.abms.org/searchdetail.asp?key=61893.

*** I take judicial notice of both board certification in radiology and B-reader certification.

Pulmonary Function Studies[5]

Exhibit #	Physician	Date of Study	Tracings Present?	Flow-Volume Loop?	Broncho-dilator?	FEV 1	FVC/ MVV	Age/ Height	Qualify?	Coop and Comp. Noted
DX 13	Taylor	7/19/05	Yes	Yes		1.14	1.97/23	69/68	Yes	No
DX 17	Castle	10/19/05	Yes	Yes	Yes	Pre: 1.13 Post: 1.39	Pre: 2.07/ 29 Post: 2.41/no MVV	69/68	Yes	Yes
EX 11	McSharry	9/12/06	Yes	Yes	Yes	Pre: .98 Post: .84	Pre: 1.66/24 Post: 1.86/ no MVV	70/65[6]	Yes	Yes

Arterial Blood Gas Studies[7]

Exhibit #	Physician	Date of Study	Altitude	Resting (R) Exercise (E)	PCO2	PO2	Qualify?	Age	Comments
DX 17	Castle	10/19/05		R	36.5	86.6	No	69	Doesn't qualify in any altitude; resting ABGs are normal, Carboxyhemoglobin

[5] 20 C.F.R. 718 Appx. B establishes the standards for the administration and interpretation of pulmonary function tests.

[6] There is some discrepancy regarding Miner's height in the record. Throughout the record his height has been reported to be between 67 and 69 inches, with 68 inches being the most widely reported height. Only Dr. McSharry has listed Miner to be 65 inches tall. I therefore find Miner to be 68 inches in height.

[7] 20 C.F.R. 718 Appx. C establishes the standards for the administration and interpretation of arterial blood gas studies.

									level is normal; hemoglobin is reduced.
EX 11	McSharry	9/12/06		R	33	83	No	70	Doesn't qualify at any altitude.

Physician Opinions

Dr. Robert Taylor (DX 13)

Dr. Taylor was chosen to perform the Department of Labor examination; the report of this examination was issued on July 19, 2005. Dr. Taylor reported a 30 pack year smoking history. He also noted a coal employment history of 16 years. Based upon the x-ray, pulmonary function tests and arterial blood gas studies required by the Department of Labor exam, as well as Miner's medical and social histories, Dr. Taylor diagnosed both simple coal worker's pneumoconiosis (CWP) as well as severe chronic obstructive pulmonary disorder (COPD). He attributed these respiratory impairments to both coal dust exposure and smoking, although he listed smoking first. He labeled Miner's impairment as severe and opined that COPD was the major factor and CWP was the minimal factor.

Dr. James R. Castle (EX 17, DX 17, and DX 18)

Dr. Castle performed an examination of Miner on October 19, 2005 (DX 17) and provided a medical report based upon this exam on November 21, 2005. (DX 18). Dr. Castle was deposed on October 12, 2006. (EX 17). Dr. Castle reported that Miner smoked approximately half a pack per day for 42 years and quit in 1996. He also noted that Miner reported more than 20 years in the mines, but that the Department of Labor had only credited him with 19.5 years. (DX 18). In his deposition Dr. Castle discussed the potential significance of some of Miner's symptoms. He explained that wheezing around certain hairsprays and odors is a sign of hyperactive airways disease, bronchial asthma or an allergy. Dr. Castle then went on to report that the October 19, 2005 x-ray, which was obtained for the exam, did not show any changes consistent with pneumoconiosis. Dr. Castle also discussed the value of CT scans, but clarified that it is not possible to determine a profusion of opacities with a CT scan. He opined that CT scans are accepted in the medical community and are a relevant and helpful diagnostic tool in determining the cause and extent of pneumoconiosis and other lung diseases. He then reported that the CT scan he reviewed, dated May 8, 2004, did not show any changes consistent with pneumoconiosis. Dr. Castle then reviewed Miner's clinical testing and reported that Miner's pulmonary function tests were invalid because there was less than maximal effort[8], a lack of reproducibility and obstruction of the mouthpiece. He then stated that the lung volumes were probably valid and indicated an obstructive impairment. Dr. Castle opined that Miner does have a respiratory impairment, but "can't

[8] But later in the deposition, he commented that Miner was indeed cooperating and trying to do the studies. (EX 17 at 8).

accurately assess the severity because [he] doesn't have any current valid studies with which to do that". (EX 17).

In Dr. Castle's opinion, there is no evidence of coal worker's pneumoconiosis; Miner is not permanently and totally disabled as a result of coal worker's pneumoconiosis or as a result of a coal mine dust induced lung disease; and any pulmonary impairment from which Miner may suffer is unrelated to coal mine dust exposure and coal worker's pneumoconiosis. (DX 18). Dr. Castle stated that while it is not possible to accurately state whether or not he has a disabling respiratory impairment, it can be stated with reasonable medical certainty that any such impairment is not related to coal mine dust exposure. Any respiratory impairment present is due to his very long and extensive tobacco smoking habit. He concluded that Miner is very likely permanently and totally disabled as a whole man because of coronary artery disease, reduced cardiac function and possible chronic gastrointestinal bleeding, which are all conditions of the general public at large and are unrelated to coal mine dust exposure and coal worker's pneumoconiosis. He further explained that even if one were to conclude that Miner does have radiographic evidence of simple coal worker's pneumoconiosis, his opinion concerning his lack of disability due to that process would remain unchanged. (DX 18).

Dr. Roger McSharry (EX 11 and EX 16)

Dr. McSharry examined Miner on September 12, 2006, provided a report on September 29, 2006 (EX 11) and was deposed on October 9, 2006 (EX 16). Dr. McSharry noted patient's medical, surgical, family, social and occupational histories as well as Miner's medications and allergies. He also conducted an extensive review of Miner's medical records. Dr. McSharry reported that Miner smoked half a pack per day for approximately 40 years and quit smoking in 1991 because of difficulty breathing. Dr. McSharry reported a 19.5 year history of significant exposure to coal dust. Dr. McSharry opined that Miner does have a moderate to severe obstructive lung disease, which is likely not reversible and is likely to be related to his long history of smoking in the past. Dr. McSharry did not believe that the respiratory disease was related to coal dust exposure. He based this conclusion on the lack of radiographic evidence of CWP. He also says the pulmonary function tests are compatible primarily with "progressive obstructive lung disease such as emphysema". He opined that emphysema could account for many of Miner's symptoms. He then goes on to say "Emphysema is not caused by coal dust exposure, but is generally caused by the use of tobacco products in the inhaled form over many years". In his deposition, Dr. McSharry said it was highly unlikely that coal mine dust would cause a purely obstructive irreversible pulmonary impairment without causing any noticeable changes in the radiographic evidence, but was still possible. (EX 17).

Dr. McSharry also concluded that Miner was disabled by the lung disease alone and unable to perform coal mine employment. However the impairment and any resulting disability are not related to Miner's occupational history but rather to his history

of tobacco abuse. Dr. McSharry also noted that Miner had other medical problems including coronary artery disease and atrial fibrillation, a dysrhythmia requiring placement of a defribrillator and congestive heart failure. Dr. McSharry explained that all of these cardiac issues contribute to his inability to perform work and may in themselves be disabling. (EX 11).

Other Medical Evidence

Exhibit #	Physician	Type of Record	Date of Report	Summary
DX 18	Castle	CT Scan Review	11/21/05 review of 5/8/04	No coal worker's pneumoconiosis. There was evidence of previous cardiac surgery and cardiomegaly.

Hospitalization Records and Treatment Notes

Dr. Dwight Bailey (CX 1)[9]

Miner received treatment from Dr. Bailey for COPD from December 6, 2005 through July 7, 2006. COPD was a consistent diagnosis throughout the course of treatment. Dr. Bailey also discussed other medical issues including, chronic renal failure, coronary artery disease, congestive heart failure, cardiac arrhythmia and joint pain. Miner consistently reported experiencing breathing difficulties. On most visits, Dr. Bailey found poor breath sounds in the lungs. On a couple of the visits Miner's lungs were clear. He first diagnosed pneumoconiosis on December 6, 2005 and then once more on December 7, 2006. By the end of treatment, Miner was complaining of increasing shortness of breath, tightness in the chest and smothering. These treatment records culminate in a diagnosis of pneumoconiosis and COPD with a referral for a chest x-ray.

Russell County Medical Center (DX 22, EX 8 and 9)

Miner received treatment from Drs. Bailey, Humphreys and Kramer at the Russell County Medical Center. Treatment records span from April 22, 2002 through August 10, 2005. From the beginning of treatment, the doctors at the Medical Center noted pulmonary hyperinflation. In 2004, Miner also had cardiomegaly, "minimal right parahilar atelectasis vs. early changes of pneumonia and atherosclerotic changes aorta". In May of 2005 Miner was treated for acute exacerbation of COPD. The report listed Miner as a 69 year old male who had increasing cough, congestion, wheezing and shortness of breath. Aerosol treatment did not improve these symptoms. Dr. Bailey also noted that Miner "smoke[d] a little bit, but not very much." He reported that the "respiratory rate is increased at 24 with diffuse wheezes and rhonchi in both lung fields

[9] A few treatment notes from Dr. Susan B. Humphreys , dated August 4, 2005, were included in CX 1. The first few pages were not included in the file. The treatment notes indicate the presence of renal cell carcinoma.

and labored respirations". On August 10, 2005 Miner was treated for abdominal pain, gastrointestinal bleeding and nausea. A CT scan of the abdomen and pelvis showed "status post left nephrectomy for renal cell carcinoma, two small right nephrolithiasis without definite obstructive uropathy, bilateral pelvic calcifications, probable phleboliths, large left hepatic lobe." At that time, Dr. Bailey reported that Miner's lungs were clear to auscultation and percussion. Dr. Kramer also wrote a report on August 10, 2005. He noted that Miner's past medical history was remarkable for coronary artery disease, renal cancer, peptic ulcer disease and colon polyps. He reported that Miner was a smoker, but did not specify the length of smoking history. Dr. Kramer also reported that Miner's lungs were clear to auscultation. (DX 22).

On February 24, 2006, Miner returned to the Russel County Medical Center and was seen by Dr. Cox. Dr. Cox noted that Miner was a retired miner, used to smoke but quit in 2005. Upon examination, Dr. Cox reported that Miner's respirations were not labored, oxygen saturation was 96, lungs showed distant, poor quality breath sounds that were barely audible. He found no rales or rhonchi. Dr Cox's impressions included syncope, which was likely due to ventricular tachycardia; atherosclerotic coronary artery disease status post inferior myocardial infarction and coronary bypass surgery in 1997 and moderate left ventricular dysfunction; severe chronic obstructive pulmonary disease; status post nephrectomy for cancer with no known recurrence. "He is not short of breath, has not had any chest pain since being here … He sleeps on two pillows at home. He uses oxygen mostly at night." (EX 8). The discharge diagnoses provided by Dr. Bailey on February 25, 2006 included Discharge diagnoses included cardiac arrythmias, possible ventricular tachycardia versus supraventricular tachycardia and acute myocardial ischemia. (EX 9).

Cardiovascular Associates (DX 22)

Miner also received treatment from Cardiovascular Associates, P.C. from July 9, 2004 through August 5, 2004. On August 5, 2004, Dr. Kramer examined Miner for the purpose of assessing preoperative risk. According to the report Miner became short of breath after 50 seconds and had chronic two-pillow orthopnea. Dr. Kramer noted a smoking history of 55-60 years at half a pack per day, and reported that Miner had cut down to a few cigarettes per day. The past medical history included COPD/emphysema, dyslipidemia and diverticulitis. Dr. Kramer noted 20 years of coal mine employment. Dr. Kramer discussed Miner's chronic cough with frequent episodes of wheezing. Dr. Kramer listed the impressions, which included "coronary artery disease with recent stress echocardiogram demonstrating scar but no evidence of ischema, systolic murmur consistent with mitral regurgitation, chronic obstructive pulmonary disease, at least moderate emphysema, left renal mass, untreated lipid." One of Dr. Kramer's suggestions was that Miner cease using all tobacco products.

On November 26, 1996, Miner returned to the Cardiovascular Associates and was examined by Dr. Hixson. Dr. Hixson reported that Miner had an "abnormal persantine SPECT cardiolite study with left ventricular dilatation. The inferior and posterior walls

reveal infarction and the inferior septum reveals a mixed pattern of infarction and ischemia." (EX 2).

Holston Valley Medical Center (EX 5 through 7)

Miner was hospitalized at the Holston Valley Medical Center between February 25, 2006 and March 1, 2006. Dr. Rao provided a cardiology consultation. Dr. Rao reported that Miner had a severe oxygen dependent chronic obstructive pulmonary disease and a history of coronary artery disease. Dr. Rao also noted that Miner had an inferior myocardial infarction in 1993, a coronary artery bypass grafting in 1997 and a negative evaluation for ischemia in 2004 prior to a nephrectomy for renal cell carcinoma. Miner described a chronic stable pattern of atypical chest pain for which he occasionally used sublingual nitroglycerin which provided relief. (EX 5).

Dr. Rao then discussed Miner's pre-surgical risk factors. He identified Miner as a former heavy smoker who had quit smoking in 2005. He reported that there was no history of hypertension, diabetes or dyslipidemia. Although Dr. Rao noted that Miner had worked in the coal mines, he did not discuss the length or nature of employment. Dr. Rao also noted a past medical history of COPD, CWP, renal cell carcinoma, status post left nephrectomy, coronary artery disease, pneumonia, and remote history of gastrointestinal bleed. Upon examination, Dr. Rao found that the lungs revealed very distant breath sounds with faint expiratory wheezes and that Miner's respiratory effort was slightly increased. Impressions included ischemic cardiomyopathy with reduced ejection fraction (25%), congestive heart failure, ventricular tachycardia and syncope, acute non-ST segment elevation myocardial infarction, coronary artery disease with prior inferior myocardial infarction and coronary artery bypass grafting surgery, severe COPD (is oxygen dependent) and a history of renal cell carcinoma (treated with left-sided nephrectomy 2004). (EX 5). During the course of hospitalization Miner received a right and left heart catheterization and an implantation of permanent dual chamber pacing, ICD, with placement of a subcutaneous thoracic array. (EX 6).

Newly Submitted Evidence and the Issue of Total Disability

The determination of the existence of a totally disabling respiratory or pulmonary impairment shall be made under the provisions of § 718.204. A miner is considered totally disabled when his pulmonary or respiratory condition prevents him from performing his usual coal mine work or comparable work. 20 C.F.R. § 718.204(b)(1). Non-respiratory and non- pulmonary impairments have no bearing on a finding of total disability. Beatty v. Danri Corp., 16 B.L.R. 1-11, 1-15 (1991). A claimant can be considered totally disabled if the irrebuttable presumption of § 718.304 applies to his claim. If, as in this case, the irrebuttable presumption does not apply, a miner shall be considered totally disabled if in absence of contrary probative evidence, the evidence meets one of the § 718.204(b)(2) standards for total disability. The regulation at § 718.204(b)(2) provides that pulmonary function studies, arterial blood gas tests; a cor

pulmonale diagnosis; and/or a well-reasoned and well-documented medical opinion concluding total disability may be criteria when determining total disability.

Section 718.204(c) provides that, in the absence of contrary probative evidence, evidence which meets the quality standards of the subsection shall establish a miner's total disability. Under this section, "all the evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing by a preponderance of the evidence the existence of this element." Mazgaj v. Valley Camp Coal Co., 9 B.L.R. 1-201, 1-204 (1986). Mere weighing of like/kind evidence is not sufficient. Specifically, it is error to look at all the pulmonary function studies and conclude that the miner is totally disabled, or to look at all the blood gas studies to conclude that the miner is totally disabled. All the evidence of record must be considered in order to determine whether the record contains "contrary probative evidence." If so, this evidence must be assigned appropriate weight in order to determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." Troup v. Reading Anthracite Coal Co., 22 B.L.R. 1-11 (1999) (en banc); Fields v. Island Creek Coal Co., 10 B.L.R. 1-19, 1-21 (1987); Shedlock v. Bethlehem Mines Corp., 9 B.L.R. 1-195, 1-198 (1986).

Under § 718.204(b)(2)(i) total disability may be established with qualifying pulmonary function tests. To be qualifying, the FEV1, as well as the MVV or FVC values, must equal or fall below the applicable table values. Tischler v. Director, OWCP, 6 B.L.R. 1-1086 (1984). The reliability of a study is dependant upon its conformity to the applicable quality standards, Robinette v. Director, OWCP, 9 B.L.R. 1- 154 (1986), which is based in part upon medical opinions of record regarding reliability of a particular study. Casella v. Kaiser Steel Corp., 9 B.L.R. 1-131 (1986). In assessing the reliability of a study, greater weight may be accorded to the opinion of a physician who reviewed the tracings. Street v. Consolidation Coal Co., 7 B.L.R. 1-65 (1984). Because tracings are used to determine the reliability of a ventilatory study, a study which is not accompanied by three tracings may be discredited. Estes v. Director, OWCP, 7 B.L.R. 1-414 (1984). If a study is accompanied by three tracings, then I may presume that the study conforms unless the party challenging conformance submits a medical opinion in support thereof. Inman v. Peabody Coal Co., 6 B.L.R. 1-1249 (1984). Also, little or no weight may be accorded to a ventilatory study where the miner exhibited a poor cooperation or comprehension. Houchin v. Old Ben Coal Co., 6 B.L.R. 1-1141 (1984). However, even if the tests fail to meet regulation requirements, in Crapp v. U.S.Steel Corp., 6 B.L.R. 1-476 (1983), the Board held that a non-conforming pulmonary function study may be entitled to probative value where the results are non-qualifying.

The parties concede that the newly admitted evidence supports the finding of total disability. All of the pulmonary function tests show qualifying results.[10] Drs. Taylor and

[10] Both Drs. McSharry and Castle opined that the pulmonary function tests are invalid due to lack of effort and reproducibility. (EX 16 and 17). Dr. Castle at one point opined that Miner did not give good effort, but in the same report stated that Miner did in fact cooperate. When questioned about Miner's cooperation,

McSharry concluded that Miner had a totally disabling respiratory impairment. Dr. Castle agreed that Miner was disabled, but opined that he could not determine the degree of severity due to the invalidity of the spirometry. The combination of the qualifying pulmonary function tests and the consensus of Drs. Taylor and McSharry support a finding of total disability. I find Dr. Castle's opinion on this issue to be equivocal. I therefore find that Miner is totally disabled under the Act. Accordingly, Miner has proven an element of entitlement that was previously proven against him. I must therefore open the entire record in order to determine Miner's eligibility for Black Lung Benefits.

MEDICAL EVIDENCE OF RECORD

X-ray Reports

Between the years of 1972 and 1992, there were 42 interpretations of 12 x-rays, all of which were negative for pneumoconiosis. Starting in 1993 there were conflicting interpretations regarding the presence of pneumoconiosis. Therefore I list the interpretations of all the x-rays taken from 1993 through 2002, which is the last x-ray of record prior to the submission of new evidence.

Exhibit	Doctor	Qualifications	Date of X-ray	Film Quality	Interpretation
DX 3	Forehand	B	9/20/02	1	Metallic sternal wires
DX 3	Navani	BCR/B	3/2/02	1	Quality Reading
DX 2	Ranavaya	B*	3/6/00	1	1/0
DX 2	Patel	BCR/B	3/6/00	1	1/0 pp; em
DX 2	Branscomb	BCR/B	2/11/00	1	co
DX 2	Forehand	B	2/11/00	1	Sternal wires; surgical clips
DX 1 (former EX 3)	Pendergrass	BCR/B	11/7/96	1	Negative
DX 1 (former EX 2)	Scott	BCR/B	11/7/96	1	OD, em; hyperinflation lungs compatible with emphysema. Coronary artery calcification. Small calcified granuloma left hilum
DX 1 (former EX 2)	Wheeler	BCR/B	11/7/96	1	OD, em; hyperinflation compatible with emphysema. No evidence of silicosis or CWP.
DX 14	Navani	BCR/B	7/19/05	3	Quality Reading
DX 1 (former DX 29)	Bassali	BCR/B	4/21/95	1	1/1

Dr. Castle said that he believed that Miner's lack of effort was not "a willful thing on his part. There are some that you can tell; you can look at them and tell that they just didn't do it." Even if I find these two pulmonary function tests to be invalid, Dr. Michos validated the test performed by Dr. Taylor, which still qualifies under the Act. Based on Dr. Taylor's tests and the medical opinion evidence I still find that Miner was totally disabled.

DX 1 (former DX 29)	Bassali	BCR/B	3/9/94	2	1/1
DX 1 (former DX 20)	Gogineni	BCR/B	3/9/94	3	fr, hyperinflation
DX 1 (former DX 20)	Binns	BCR/B	3/9/94	3	Negative
DX 1 (former DX 17)	Sargent	BCR/B	3/9/94	3	fr; widened aorta, smoking history
DX 1 (former DX 17)	Fisher	BCR/B	3/9/94	1	1/1; fr
DX 1 (former DX 16)	Gaziano	B	3/9/94	1	Negative
DX 1 (former DX 29)	Bassali	BCR/B	10/29/93	1	1/1
DX 1 (former DX 32)	Spitz	BCR/B	10/29/93	1	Negative
DX 1 (former DX 32)	Wiot	BCR/B	10/29/93	1	Negative
DX 1 (former DX 20)	Binns	BCR/B	10/29/93	2	Negative
DX 1 (former DX 20)	Gogineni	BCR/B	10/29/93	2	Negative; hyperinflation
DX 1 (former DX 8)	Sargent	BCR/B	10/29/93	1	O, calcified (illegible) history
DX 1 (former DX 7)	Shahan	BCR	10/29/93	1	Negative

* I take judicial notice of B-reader certification. This physician was identified as a B-reader in the NIOSH Comprehensive Reader List found at: http://www.oalj.dol.gov/PUBLIC/BLACK_LUNG/REFERENCES/REFERENCE_WORKS/BREAD3EF_08_05.HTM.

Physician Opinions

Exhibit #	Physician	Physician Qualifications	Date of Report	Summary
DX 3	Randolph Forehand		9/20/02	Dr. Forehand credited Miner with 20 years of coal mine employment and recognized a smoking history of ½ to ¾ of a pack per day from 1975 to 2000. Dr. Forehand diagnosed chronic bronchitis based upon Miner's history, physical exam and pulmonary function studies. Dr. Forehand attributed the bronchitis to cigarette smoking. Dr. Forehand once again recognized a respiratory impairment, but states that "sufficient residual ventilatory capacity remains to continue working in [his] last coal mining job." (DX 3).
DX 2	D. L. Rasmussen		3/6/00	Dr. Rasmussen indicated that Miner's father had suffered from emphysema and Black Lung. Dr. Rasmussen noted a coal mine employment history in excess of 19 years. Dr. Rasmussen reported a 22.5 pack year smoking history. Dr. Rasmussen listed three cardiopulmonary diagnoses which included coal worker's pneumoconiosis, chronic obstructive pulmonary disorder and asthma as well as atherosclerotic coronary heart disease. He based his diagnosis of pneumoconiosis on the radiographic evidence and the length of coal mine employment. He based his diagnosis of COPD on the findings of a reversible obstructive impairment. He opined that the pneumoconiosis was caused by coal mine dust exposure and that the COPD was caused by a combination of coal mine dust exposure, tobacco smoking and other undetermined factors. Pertaining to Miner's level of disability, Dr. Rasmussen stated "the patient has moderate, but significantly reversible obstructive ventilatory impairment. Based upon these studies, he retains the pulmonary capacity to perform his last coal mine job." (DX 2).

DX 2	Randolph Forehand	2/11/00	Dr. Forehand noted 19.5 years of coal mine employment and a 50 pack year smoking history; he reported that Miner quit in 1998. Based upon the radiographic evidence, miner's history and clinical testing, Dr. Forehand did not find coal worker's pneumoconiosis. He did find that Miner suffered from chronic bronchitis and atherosclerotic coronary heart disease. He attributed the cardiopulmonary diagnoses to cigarette smoking. Dr. Forehand reported that chronic bronchitis is the sole factor contributing to Miner's respiratory impairment. Although Dr. Forehand acknowledged a respiratory impairment, he clarified that if Miner used a bronchodilator he could return to his last coal mining position.
DX 1 (Former DX 36)	J. Dale Sargent	11/11/96	Dr. Sargent noted a coal mining employment history of 19.75 years and a smoking history in excess of 15 pack years and reported that Miner quit in 1993. Dr. Sargent opined that Miner did not suffer from pneumoconiosis. He based this finding, in part, on a negative x-ray reading, which is consistent with the finding of this Court. In Dr. Sargent's opinion, Miner has a very minimal obstructive impairment that was due to cigarette smoking. He claimed that the impairment was not caused by coal dust exposure, because coal worker's pneumoconiosis typically yields a mixed obstructive and restrictive pattern, coupled with positive x-ray findings. Neither of which were present in this case.
DX 1	Randolph Forehand	4/21/92	Diagnosed COPD due smoking and coal dust exposure. He reported that Miner experienced black mucus nightly.

Relevant Hospitalization Records and Treatment Notes

Exhibit #	Beginning and Ending Dates of Hospitalization/ Treatment	Name of Hospital/ Physician	Nature of Treatment	Summary
DX 1 (former DX 31)	4/12/93 – 4/13/93	Holston Valley Hospital and Medical Center	Hospital Report and Discharge summary	Miner was admitted for treatment of a myocardial infarction. Miner underwent a cardiac catheterization which provided no etiology for his dyspnea on exertion. The day following the catheterization, "Miner was ambulating with no further chest pain or dyspnea." The hospital staff noted a past history of COPD, and prior hospitalizations for pneumonia and bronchitis. The staff also reported an employment history of 20 years and a smoking history in excess of 30 years. The reported impressions included acute inferior myocardial infarction, COPD and tobacco dependence.

Other Medical Evidence

Exhibit #	Physician	Type of Record	Date of Report	Summary
DX 1 (former DX 22)	Dr. Fowler	CT Scan	9/1/88	Specifically, no masses, effusions, lymphadenopathy or other pathology is identified. Normal CT scan of the chest.

DISCUSSION AND APPLICABLE LAW

Total Disability

There are many non-qualifying arterial blood gas study and pulmonary function test results through out the record. The medical evidence from the first claim does not support a finding of total disability. A mild reversible impairment was detected over time and recorded in the medical evidence included with the second and third claims. This impairment slowly worsened. The newly submitted evidence offers the strongest support for the finding of total disability. More weight may be accorded to the results of a recent ventilatory study over the results of an earlier study. Coleman v. Ramey Coal Co., 18 B.L.R. 1-9 (1993). And a medical report containing the most recent physical examination of the miner may be properly accorded greater weight as it is likely to contain a more accurate evaluation of the miner's current condition. Gillespie v. Badger Coal Co., 7 B.L.R. 1-839 (1985). I therefore grant the most weight to the new evidence and find that Miner is totally disabled as defined under the Act.

Pneumoconiosis

Under the Act, "'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b). Section 718.202(a) provides four methods for determining the existence of pneumoconiosis. Under Section 718.202(a)(1), a finding of pneumoconiosis may be based upon x-ray evidence. In evaluating the x-ray evidence, I assign heightened weight to interpretations of physicians who qualify as either a board-certified radiologist or "B" reader. Dixon v. North Camp Coal Co., 8 BLR 1-344, 1-345 (1985). I assign greatest weight to interpretations of physicians with both of these qualifications. Woodward v. Director, OWCP, 991 F.2d 314, 316 n.4 (6th Cir. 1993); Sheckler v. Clinchfield Coal Co., 7 BLR 1-128, 1-131 (1984). [11]

[11] Many of the x-ray interpretations in the record are not recorded on an ILO-UICC/Cincinnati Classification of Pneumoconiosis form, which is the most widely used system for the classification and interpretation of X-rays for the disease pneumoconiosis. Some of these narrative x-ray interpretations specifically reject the diagnosis of pneumoconiosis, however most are silent on the issue. In Marra v. Consolidation Coal Co., 7 B.L.R. 1-216 (1984), a case arising under Part 727, the Board held that, under some circumstances, it is proper for the administrative law judge to infer that an interpretation, which does not mention the presence of pneumoconiosis, as negative. On the other hand, in Sacolick v. Rushton Mining Co., 6 B.L.R. 1-930 (1984), the Board upheld invocation under §727.203(a)(1) where one x-ray was interpreted as positive for the disease and the remainder of the studies, which were interpreted for purposes of diagnosing cancer, included no diagnosis of pneumoconiosis. See also Billings v. Harlan #4 Coal Co., BRB No. 94-3721 BLA (June 19, 1997)(en banc)(unpublished) (Board reiterated that 'when an x-ray is not classified, and makes no mention of pneumoconiosis, the administrative law judge has discretion to infer whether or not the x-ray is negative for pneumoconiosis'). In this case, every narrative x-ray was conducted for the purpose of diagnosing a pulmonary disease and not for any other reason, so if a physician found pneumoconiosis I assume he would have included such findings in the x-ray report as they would be relevant to the purpose of the study. I therefore find every narrative x-ray that is silent on the issue of pneumoconiosis in this case to be negative.

The interpretations of all the x-rays dated before October 29, 1993, are negative for pneumoconiosis. In addition, all the interpretations were negative for the following x-rays: November 7, 1996; February 11, 2000; September 20, 2002; December 17, 2003; August 11, 2005; October 19, 2005; November 9, 2005; February 28, 2006; March 1, 2006; July 7, 2006 and September 12, 2006. I find the 12 x-rays taken prior to 1993 to be negative for pneumoconiosis. I find the above eleven x-rays, taken 1993 or later, to be negative for pneumoconiosis.

A dually qualified specialist delivered the only interpretation of the April 21, 1995 x-ray, which was positive for pneumoconiosis with a profusion of 1/1. I find this x-ray to be positive for pneumoconiosis.

There are seven interpretations of the October 29, 1993 x-ray, only one of which is positive for pneumoconiosis with a profusion of 1/1. All of the physicians that interpreted this x-ray were board certified in radiology. I find this x-ray to be negative for pneumoconiosis. Five dually qualified specialists read the March 9, 1994 x-ray. Three interpretations were negative for pneumoconiosis, and two were positive with a profusion of 1/1. I find this x-ray to be negative for pneumoconiosis. The March 6, 2000 x-ray was interpreted by three dually qualified specialists and one B-reader. Two dually qualified specialists found the x-ray to be negative for pneumoconiosis, while the other dually qualified specialist and the B-reader found the x-ray to be positive with a profusion of 1/1. I find this x-ray to be negative for pneumoconiosis. A dually qualified specialist found the July 19, 2005 x-ray to be negative for pneumoconiosis with a profusion of 0/1, where as a physician, who was neither board certified in radiology nor a B-reader, read the x-ray to be positive with a profusion of 1/1. I grant more weight to the interpretation given by the dually qualified specialist and therefore find this x-ray to be negative for pneumoconiosis.

I only found one x-ray to be positive for pneumoconiosis. This x-ray was taken in 1995 and only interpreted by one specialist. Considering the fact that I found every other x-ray to be negative for pneumoconiosis, including all the most recent radiographic evidence, I find that Claimant is unable to establish the presence of pneumoconiosis through radiographic evidence under 20 C.F.R. §718.202(a)(1).

Under § 718.202(a)(2), a claimant may establish pneumoconiosis through biopsy evidence. This section is inapplicable to this claim because the record contains no such evidence.

Under § 718.202(a)(3), a claimant may prove the existence of pneumoconiosis if one of the presumptions at §§ 718.304 to 718.306 applies. The presumptions at §§ 718.305 and 718.306 are inapplicable because they only apply to claims that were filed before January 1, 1982, and June 30, 1982, respectively. Section 718.304 requires x-ray, biopsy, or equivalent evidence of complicated pneumoconiosis. Complicated

pneumoconiosis is diagnosed after a finding of an opacity greater than one centimeter is categorized as a type A, B or C. No such evidence is present in this case, and so this section is also inapplicable.

The final method by which Claimant can establish that he suffers from the disease is by well- reasoned, well-documented medical reports as per §718.202(a)(4). A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's history. Hoffman v. B&G Construction Co., 8 B.L.R. 1-65 (1985); Hess v. Clinchfield Coal Co., 7 B.L.R. 1-295 (1984). A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation adequate to support the physician's conclusions. Fields, supra. Indeed, whether a medical report is sufficiently documented and reasoned is for the administrative law judge as the finder-of-fact to decide. Clark v. Karst-Robbins Coal Co., 12 B.L.R. 1-149 (1989)(en banc). Moreover, statutory pneumoconiosis is established by well-reasoned medical reports which support a finding that the miner's pulmonary or respiratory condition is significantly related to or substantially aggravated by coal dust exposure. Wilburn v. Director, OWCP, 11 B.L.R. 1-135 (1988).

Medical opinion evidence may establish either clinical or legal pneumoconiosis. Under the Act, "'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b). "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment. §718.201(a)(1-2).

Clinical Pneumoconiosis

Based on the July 19, 2005 x-ray, Dr. Taylor concluded that Miner suffered from simple coal worker's pneumoconiosis. Dr. Taylor had read that x-ray to be positive for pneumoconiosis, which is contrary to the finding of the Court. It is proper for the administrative law judge to accord less weight to a physician's opinion that is based on premises contrary to the judge's findings. Furgerson v. Jericol Mining, Inc., 22 B.L.R. 1-216 (2002)(en banc) (the ALJ 'did not reconcile (a) physician's diagnosis of pneumoconiosis, based upon the positive x-ray and the miner's significant duration of coal dust exposure, with the fact that Dr. Baker's positive interpretation was reread as negative by a physician with superior qualifications'; as a result, the Board directed that the ALJ 'address whether this rereading impacts the physician's opinion and his diagnosis

of pneumoconiosis'). Dr. Taylor provided no other explanation for the diagnosis of coal worker's pneumoconiosis. I therefore grant Dr. Taylor's opinion little weight.

Dr. Castle opined that there was no evidence of coal worker's pneumoconiosis. He based this opinion on the radiographic, CT scan evidence, the lack of consistent physical findings and an extensive review of the medical evidence. The x-ray he obtained for the report was negative, and the CT scan he reviewed also failed to show any changes consistent with coal worker's pneumoconiosis. He also explained that Miner did "not demonstrate the consistent physical findings of an individual with an interstitial pulmonary process… findings of rales, crackles or crepitations." (DX 18). I find Dr. Castle's opinion to be well-documented and well-reasoned. The review of medical evidence validated the results from his medical evaluation of the miner. Dr. Castle reviewed nearly every piece of medical evidence found in the record. This review and his examination of Miner enabled Dr. Castle to write a very well-documented report. Dr. Castle articulated the basis for each of his conclusions. I therefore find Dr. Castle's opinion to be of great probative value.

After conducting an examination of Miner on September 12, 2006 and a review of Miner's medical, social and occupational histories, Dr. McSharry concluded that Miner did not suffer from coal worker's pneumoconiosis. Dr. McSharry based this conclusion on the lack of radiographic evidence showing clinical pneumoconiosis. He found the x-ray evidence to be negative for pneumoconiosis, which is consistent with the findings of this Court. The documentation reviewed was sufficient to allow Dr. McSharry to make such a conclusion. Dr. McSharry's opinion is both well-reasoned and well-documented and accordingly I find his opinion to be probative on this issue.

Between the years of 1992 and 2002, three physicians offered opinions regarding Miner's respiratory impairment. Dr. Forehand provided three medical opinions dated September 20, 2002, February 11, 2000 and April 21, 1992. He failed to diagnose clinical pneumoconiosis in any of these reports. In his November 11, 1996 report, Dr. Sargent concluded that Miner did not suffer from pneumoconiosis based upon a negative x-ray interpretation. Dr. Rasmussen was the only physician of the three that diagnosed coal worker's pneumoconiosis. Dr. Rasmussen based this diagnosis on the March 6, 2000 x-ray. He found this x-ray to be positive for pneumoconiosis, which again is contrary to the finding of the Court, and therefore I grant Dr. Rasmussen less weight.

The hospital and treatment records fail to support a finding of clinical pneumoconiosis. Dr. Bailey was one of Miner's treating physicians. The adjudication officer must give consideration to the relationship between the miner and any treating physician whose report is admitted into the record. 20 C.F.R. 718.104(d). In appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officer's decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole. 20 C.F.R. 718.104(d)(5). Dr. Bailey diagnosed pneumoconiosis once in 2005 and

again in 2006. However he provides no basis or explanation for these diagnoses. Dr. Bailey's role as Miner's treating physician does not outweigh the fact that Dr. Bailey's opinion is not well reasoned. The only mention of coal worker's pneumoconiosis found in any of the treatment or hospital records are references to a past diagnosis of pneumoconiosis noted in Miner's past medical history. I therefore find neither Dr. Bailey's treatment records, nor the hospital records to be particularly probative.

I find the opinions delivered by Drs. Castle and McSharry to be the most persuasive on the issue of clinical pneumoconiosis. Therefore the physician opinion evidence does not support a finding of clinical pneumoconiosis.

Legal Pneumoconiosis

Every physician diagnosed Miner with some sort of obstructive impairment including chronic bronchitis, asthma, emphysema and COPD. A pulmonary disease may constitute statutory pneumoconiosis if it is significantly related to or aggravated by dust exposure in coal mine employment. The legal definition of pneumoconiosis is broad and may encompass more respiratory or pulmonary conditions than those specifically, clinically diagnosed in a medical opinion. For example, a physician may conclude that the miner suffers from asthma, which is related to his coal dust exposure. Although the physician did not specifically state that the miner suffered from pneumoconiosis or black lung disease, the respiratory condition that he diagnoses is related to coal dust exposure and, therefore, is supportive of a finding of legal pneumoconiosis. Any of the above diagnoses could potentially fit the definition of legal pneumoconiosis, so long as the physician relates the diagnosis to coal dust exposure.

Drs. Taylor, Rasmussen and Forehand opined that Miner's obstructive impairment was caused in part by coal dust exposure. In 1992, Dr. Forehand diagnosed COPD and attributed this disease to both smoking and coal dust exposure. However, ten years later, Dr. Forehand opined that Miner suffered from chronic bronchitis caused solely by tobacco smoking. He failed to address the effect of coal mine employment. Dr. Forehand's opinions are conclusory, poorly reasoned and internally inconsistent, and therefore not probative on the issue of legal pneumoconiosis. Dr. Rasmussen diagnosed COPD and reported that this obstructive impairment was caused by "coal mine dust, cigarette smoking and others?" That is the only statement connecting Miner's obstructive impairment with coal dust exposure. I find this peripheral statement to be vague at best. Dr. Taylor diagnosed both CWP and COPD, and opined that COPD was the primary cause of Miner's impairment. He attributed both diseases to tobacco smoking and coal dust exposure, but lists tobacco smoking as the primary contributor. Although Dr. Taylor does not provide any further explanation of his conclusions, I do find his opinion to be clear and sufficiently documented. I therefore find Dr. Taylor's opinion to be probative of the issue.

In order to determine whether Miner suffered from legal pneumoconiosis, I rely primarily on the opinions of Drs. Castle and McSharry. Both physicians opined that Miner's obstructive impairment was not due to coal mine dust exposure, and rather

attributed this impairment to tobacco smoking.[12] Both physicians conducted the most extensive review of medical evidence. I find their opinions to be better documented than the other physician opinions of record. I also note Dr. Castle's impressive qualifications, which include academic appointments at a number of universities, board certification in internal medicine and pulmonary disease and numerous publications and presentations on various pulmonary diseases. (EX 17). Dr. McSharry's qualifications are not as impressive as Dr. Castle's but still include board certification in both internal and pulmonary medicine. (EX 16). Dr. Taylor's curriculum vitae is not included in the record, however there is a statement asserting that Dr. Taylor is board certified in internal medicine. (DX 13). Dr. Rasmussen's credentials are also not included in the record. Dr. Castle recognized the correct smoking and occupational histories, and opined that Miner's obstructive impairment was due to tobacco smoking. Dr. McSharry agreed and further explained that, while not impossible, it was unlikely that a purely obstructive impairment would be caused by coal dust exposure without exhibiting any radiographic evidence. I find the opinions of Drs. McSharry and Castle to be the most persuasive.

Dr. Sargent also found that Miner had suffered from an obstructive impairment, but attributed the impairment to cigarette smoking. The explanation he provided for this conclusion was that coal dust exposure typically yields a mixed obstructive and restrictive pattern coupled with positive x-ray findings and that neither were present in this case. Even though Dr. Sargent has less impressive credentials, and based his opinion on less documentation than either Dr. Castle or McSharry, I still find his opinion to be probative. I rely on the consensus between Drs. Castle, McSharry and Sargent and therefore find that Miner did not establish the existence of legal or clinical pneumoconiosis.

ORDER

Claimant's claim for benefits under the Act is hereby **DENIED.**

A

LARRY W. PRICE
Administrative Law Judge

[12] Drs. Cox and Rao also diagnosed COPD, but failed to provide any etiology. Dr. Kramer diagnosed COPD, did not provide any etiology but did advise Miner to quit smoking. I find none of the above opinions to be very helpful in the analysis of this issue.

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).